CBHS Corporate Health Pty Ltd
ABN 85 609 980 896

Health Management Program Authorisation

Send this form along with your claim form and relevant receipts to:

Post: Locked Bag 5098
Parramatta, NSW, 2124

Email: wellness@cbhscorp.com.au

Under CBHS Corporate Health Wellness Benefits, members can claim towards a health management program. The benefit is available to members if the health management program **is designed to improve or reduce a specific health or medical condition.**

Please submit this form along with your completed claim form and relevant receipts for the health management program.

Section 1 - Details of claimant

CBHS Corporate Health Membership No. ______________________ Date of Birth ______________________

Claimants First Name ______________________ Claimants Last Name ______________________

Section 2 - To be completed by your health practitioner. (GP, Specialist, Physiotherapist or Allied Health service providers)

Practioners Name ______________________ Provider Number ______________________

Phone number (incl. area code) ______________________ Postcode ______________________

Please indicate the patient's medical condition

Please indicate the health management regime you are recommending to improve the patient's medical condition.

This regime will require: ☐ Gym membership ☐ Personal trainer

Please indicate the length of time you are recommending for this course of treatment __________ months.

Declaration (to be completed by the practioner)

I declare that the information I have provided is true and correct.

Practioners signature and practice stamp.

Date ______________________

Section 3 - Additional information

Is this claim a result of an accident or trauma: ☐ Yes ☐ No If 'Yes', please give the date of the event ______________

Is the claimant entitled to any form of compensation, damages or payment as a result of this accident or trauma? ☐ Yes ☐ No

If 'Yes', please provide brief details ______________________

Your GP's Name ______________________

Declaration of Authority, I declare that:

- the documents attached, supporting this claim, are for services rendered to myself or a dependant listed on my membership, and
- the information I have provided is true, complete and correct, and
- the claim is received as part of a health management program intended to improve or reduce a specific health condition(s).

I authorise CBHS Corporate Health Pty Ltd to contact the provider of any service claimed and obtain any information relating to the claim.

Signature of Member (or Authorised Partner)

Date ______________________

Privacy

How CBHS Corporate Health collects, uses and secures your personal information is described in the CBHS Corporate Health Privacy Policy. CBHS' Privacy Policy is availbale at **www.cbhscorporatehealth.com.au** or by calling **1300 586 462**